CONNER STRONG & BUCKELEW

# NATIONAL HEALTH INSURANCE REFORM

*Outline of the Major Provisions of New Landmark Legislation*

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## With the passage of national health insurance reform now complete, this analysis is intended to provide an assessment of the various provisions of the new laws. As the final regulations are issued, additional updates will be distributed:

While there are several immediate changes, the major aspects of health care reform will not take effect until 2014. Until then there are a number of reforms that are a number of reforms that are effective for plan years that begin on or after six months after the enactment date. There are also a number of tax provisions with varying effective dates. To ensure compliance with the new laws, employers will be required to take immediate action to examine the changes and how they impact their group health and welfare plans.

These new provisions will be added to the Public Health Service Act (PHSA) and incorporated by reference into ERISA and the Internal Revenue Code (the "Code"). For the most part, the reforms are effective for plan years beginning six months after the date of enactment. This generally means January 1, 2011 for calendar year plans and as soon as this year for plans that have a plan year beginning October 1 or later this year. Note that the new provisions impact both self-insured and fully-insured group health plans.

## IMMEDIATE CHANGES

- **Annual and Lifetime Maximums –** Plans may not impose lifetime limits and only restricted annual limits, as determined by the Secretary of Health and Human Services (HHS), on the value of essential benefits (as defined by the legislation) for any participant or beneficiary. For plan years beginning on or after January 1, 2014 group health plans and group health insurers may not impose any annual limit. Otherwise permissible lifetime or annual limits may be imposed on specified covered benefits that are not essential health benefits. "Essential health benefits" will be defined by the HHS;
- **Coverage of Adult Children –** Plans that cover dependent children must provide for coverage of unmarried children until age 26 regardless of whether the child is a student or not. There is no requirement to cover children of covered dependent children. The requirement is applicable even if the child is not a tax dependent. Further, the law extends the requirement to married children and extends the tax exclusion for employer-provided coverage to adult children through age 26;

- **Coverage of Preventive Care –** Plans must provide first dollar coverage (i.e., no cost sharing) for certain evidence based preventive care (including well child care) and certain immunizations;
- **Standard Explanations of Coverage –** The plan administrator (in the case of a self-insured plan) or the insurance company (in the case of a fully-insured plan) must prepare and distribute a paper or electronic summary of coverage to all applicants and all enrollees, both at the time of initial enrollment and annual enrollment. This is in addition to the Summary Plan Description already required by ERISA. The summary must satisfy certain uniform standards developed by the Secretary of HHS, including but not limited to: (i) no more than four pages in length with print no smaller than 12 point font, (ii) written in a culturally and linguistically appropriate manner, and (iii) containing certain contents related to the covered benefits, exclusions, cost sharing, and continuation. HHS must establish the standards within 12 months of the date of enactment and the summary must be provided within 24 months after the date of enactment. In addition, the plan or the issuer (as applicable) must notify enrollees of material changes to the coverage reflected in the most recent summary no less than 60 days in advance of the effective date of such coverage. Failure to comply may result in a $1,000 penalty for each failure;
- **Prohibition on Rescinding Insurance –** Plans may not rescind coverage except in cases of fraud or intentional misrepresentation;
- **Transparency Requirements –** Group health plans and health issuers in the group market are subject to the same transparency requirements applicable to plans offered in the new state exchanges to be built for 2014. Under these requirements, such plans and issuers must provide to the Secretary of HHS, the applicable state insurance commissioner and the public the following information: 1) claims payment policies and data, 2) financial disclosures, enrollment (and disenrollment) data, 3) data on rating policies, 4) information on cost-sharing and payments with respect to out of network coverage and 5) information on participant rights under the Act and other information as determined by the Secretary of HHS;
- **Nondiscrimination Rules for Fully-Insured Plans –** The nondiscrimination rules of Code Section 105(h) previously applicable only to self-insured health plans will be extended to fully-insured group health plans;
- **Pre-existing Condition Exclusions –** With respect to children under age 19, plans may not impose a pre-existing condition exclusion or limitation;
- **Quality of Care –** Plans must annually report to HHS and to enrollees (during each open enrollment period) regarding benefits under the plan that improve health such as case



management, disease management, and wellness and health promotion activities. HHS is to develop the reporting standards within two years of the enactment date;

- **Cost Reporting and Rebate Requirements –** A health insurance issuer offering group coverage must submit to the Secretary of HHS a report relating to loss ratios. Rebates to enrollees must be provided if the medical loss ratio is 85% (80% in the small group market) or such higher amount as permitted under state law;
- **Claims Procedures –** Plans must establish an internal claims appeals process that 1) provides notice in a culturally and linguistically appropriate manner of the review process and availability of any applicable health insurance ombudsman created by a state to assist claimants with appeals, 2) allows claimants to review the entire claim file and present evidence, 3) allows claimants to continue receiving coverage during the appeals process, and 4) initially incorporates the claims review procedures set forth in Department of Labor regulations that apply to plans covered by ERISA. Plans must also establish an external review process that complies with applicable state law and that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act developed by the NAIC or, in the case of self-insured plans, meets similar requirements as provided by the Secretary of HHS. The Secretary of HHS may deem the existing external review process of a group health plan to be in compliance with the provisions of the bill;
- **High Risk Insurance Pools –** Until the high risk pool established for individuals with pre-existing conditions is terminated in 2014, a group health plan must reimburse the high risk pool for medical expenses incurred by the pool for individuals found to have been offered financial incentives to dis-enroll from the group health plan;
- **New Electronic Transaction Standards –** Plans must implement certain electronic transaction standards and certify compliance to HHS. The timing of certification varies depending on the type of transaction. Health plans must certify compliance with electronic fund transfer, health claim status and health care payment and remittance advice standards established no later than December 31, 2013. Compliance with other standards such as the health claims or equivalent encounter standard is due no later than December 31, 2015;

## STATE BASED HEALTH INSURANCE EXCHANGES/MARKETS

The laws require states to establish a health insurance exchange through which individuals may purchase health insurance beginning in 2014. Although generally intended for individuals, the exchange-related provisions impact employers in the following ways:



- Beginning in 2017, states may allow all employers of any size to offer coverage through the exchange;
- Prior to 2017, only small employers (employers with 100 employees or fewer) may participate. For years before 2016 a state could limit small employers to those with 50 or fewer employees;
- Employers who offer coverage through the exchange may permit employees to pay for such coverage with pre-tax dollars through the employer's cafeteria plan. However, exchange-related coverage that is not offered by the employer may not be offered through the employer's cafeteria plan.

## HEALTH INSURANCE MARKET REFORMS

Group health plans and health plan insurers are subject to the following general insurance market reforms. These reforms are generally effective for plan years beginning on or after January 1, 2014:

- **Prohibition on Preexisting Exclusion Limitations –** No preexisting condition exclusions or limitations are permitted;
- **No Discrimination Based on Health Status –** The same rules that currently exist under HIPAA apply. However, the new law raises the maximum incentive amount for wellness programs that provide the incentive based on achieving a health standard from 20% of the COBRA cost of coverage to 30% of the COBRA cost of coverage for those participating in the program. The law also allows the Secretaries of DOL, HHS and Treasury leeway to increase the percentage to 50%;
- **Cost-Sharing Limitations –** Certain cost-sharing requirements must be satisfied. Out-of-pocket (OOP) expense may not exceed that applicable to Health Savings Account (HSA) related coverage and deductibles do not exceed $2,000 for single coverage and $4,000 for family coverage, as indexed;
- **Limitation on Waiting Periods –** Plans may not impose a waiting period more than 90 days. There is also an excise tax penalty for waiting periods imposed on full-time employees;
- **Participation in clinical trials –** A plan may not deny qualifying individuals participation in certain clinical trials or deny the coverage of routine patient costs for items and services furnished in connection with the clinical trial;

## INDIVIDUAL INSURANCE MANDATE

Effective January 1, 2014 individuals who do not enroll in qualifying coverage, including qualifying employer-sponsored coverage, must pay an excise tax. Self-insured plans and insurers will be required to report certain coverage-related information to the individual and to the IRS. Under the law, individuals generally pay the greater of a flat dollar amount and a percentage of income payment. The flat dollar amount penalty is $95 in 2014, $495 in 2015 and $750 in 2016 and thereafter. The percentage of income limit is 0.5% in 2014, 1.0% in 2015, and 2.0% in 2016 and thereafter.

## NEW EMPLOYER RESPONSIBILITIES

Effective for months beginning on or after January 1, 2014, employers must comply with:

- **Automatic Enrollment –** Large employers with 200 or more full-time employees that offer at least one health plan benefit option must automatically enroll all new employees in a benefit option and continue the enrollment of current employees in a health benefit plan offered by the employer. The auto-enrollment program must include adequate notice and the opportunity for an employee to opt out of the "auto" coverage and elect another option, or opt out altogether;
- **Notification of Availability of Exchanges and Subsidies –** Employers must notify each employee at the time of hiring of the following; 1) the existence of the exchange, 2) that the employee may be eligible for a subsidy under the exchange if the employer's share of the total cost of benefits is less than 60% and 3) that if the employee purchases a policy through the exchange, he or she will lose the employer contribution to any health benefits offered by the employer;

## EMPLOYER PENALTIES

- There is no requirement for employers to offer the same coverage that insurers offering coverage in the exchange must offer. Also, there is generally no requirement for employers to offer any coverage. However employers with 50 or more full-time employees are subject to penalties related to coverage that they offer or fail to offer to full-time employees;
- Applicable Employers who fail to offer any full-time employees health coverage must pay a penalty. Also for each full-time employee in any month in which any employee enrolls in

and receives a subsidy for the exchange the penalty shall apply. The penalty is $2,000 per year times the number of employees. The first 30 employees of a company are precluded from the tax

- Applicable Employers offering coverage for any month to a full-time employee who is certified as having enrolled in the exchange and received a tax subsidy are subject to a penalty equal to the product of the total number of such employees (i.e., employees receiving the credit) and 1/12 of $3,000 (400% of the applicable payment amount, which is $750). The amount of the tax in this instance is limited to 1/12 of $750 multiplied by the total number of the employer's full- time employees. Note that an employee who is offered employer coverage is not eligible for a credit unless the employee's required premium for the coverage exceeds 9.5% of the individual's household income or the plan's share of allowed costs under the plan is less than 60%;
- Note that a large employer is defined as an employer (and any other employer within the same controlled group) who employed on average at least 50 full-time employees on business days during the preceding year. However, an employer is not considered to be a large employer if the employer did not employ more than 50 full-time employees for more than 120 days during the preceding year. A "full-time employee" is defined as an employee who is employed on average at least 30 hours of service per week;
- Certain "seasonal workers" are not counted as full-time employees;
- Part-time employees are taken into account solely for the purpose of determining if an employer has at least 50 employees. The number of full-time employees otherwise determined is increased by dividing the aggregate number of hours of service of employees who are not full-time employees by 120;

## REPORTING REQUIREMENTS

Employers must report to the Secretary of Treasury each year, certifying 1) whether coverage is offered to full-time employees, 2) the waiting period for any such coverage, 3) the number of full-time employees of the employer during each month, and 4) the name, address and TIN of each full-time employee and the months during which they were covered under the plan;

## FREE CHOICE VOUCHERS

Employers that offer minimum essential coverage and make a contribution must offer free choice vouchers to qualified employees for the purchase of qualified health plans through exchanges. The free choice voucher must be equal to the contribution that the employer would have made to its own plan. Employees qualify if their household income does not exceed 400% of the federal poverty level and the required contribution under the employer's plan would be between 8 and 9.8% of their income. Free choice vouchers are excludible from employees' incomes and deductible by the employer. Voucher recipients are not eligible for tax credits through the exchange;

## THE CADILLAC TAX

The tax is delayed until 2018. The thresholds for the tax are increased to $10,200 for single coverage and $27,500 for family coverage ($11,850 and $30,950 for retirees and employees in high risk professions). These amounts are to be adjusted automatically if health costs increase by more than anticipated before 2018. The thresholds are increased by CPI + 1 in 2019 and by CPI thereafter. An employer may make an adjustment to reduce the cost of plans when calculating the tax if the employer's age and gender demographics are not representative of a national average.

## OTHER GROUP HEALTH PLAN ISSUES

- **FSA Maximum –** Effective taxable years beginning January 1, 2013 health FSA salary reductions are limited to $2,500 each year. The cap is indexed to the CPI starting in 2014.
- **Over-the-counter Medication Reimbursements –** Effective for tax years beginning on or after January 1, 2011, over-the-counter medicines or drugs are not eligible for reimbursement under an FSA, HRA or HAS;
- **HSA Distributions –** The excise tax for nonqualified distributions from HSAs is increased to 20%, effective for distributions after December 31, 2010;
- **Deduction of Retiree Medical –** Effective January 1, 2013 the tax deduction previously permitted for amounts attributable to the Medicare Retiree Part D subsidy is eliminated.
- **High Income Tax Changes –** Starting in 2013, individuals with wages above $200,000 for a single return and $250,000 for a joint return would be subject to an additional 0.9% tax

on wages in excess of these thresholds. Also, such individuals would also be subject to a 3.8% tax on their net investment income (to the extent that total income exceeds the thresholds). This new tax would be effective starting in 2013;

## SAFE HARBOR RULES FOR CAFETERIA PLANS OF SMALL EMPLOYERS

A new safe harbor from the nondiscrimination rules for cafeteria plans (and certain plans offered through a cafeteria plan, such as group term life insurance, self-insured medical and dependent care assistance benefits) is provided for plans maintained by eligible employers to the extent certain requirements are met, such as 1) all "non excludable" employees are eligible to participate and 2) certain minimum contribution requirements are met. An eligible employer is an employer with 100 or fewer employees during either of the two preceding years (provided it is a full year). The safe harbor applies for tax years beginning on or after January 1, 2011.

Also, effective for taxable years beginning on or after January 1, 2011, small employers with fewer than 25 "full-time equivalent" employees are eligible for a tax credit equal to a portion of the employer's cost to provide health insurance.

## FEES AND TAXES ON HEALTH INSURANCE COMPANIES

Effective starting in 2014, there is a nondeductible annual fee on health insurance providers based on market share.

- The fee is structured to raise $60 billion over 10 years;
- The fee does not apply to self-insured plans. Certain other exceptions also apply. The fee does not apply to long-term care coverage or to coverage for specified disease or hospital indemnity policies;
- To fund comparative effectiveness research, effective for each policy year ending after September 30, 2012, a fee equal to $2 ($1 in the case of policy years ending during fiscal year 2013) multiplied by the average number of covered lives will be imposed. The fee applies to accident or health insurance policies other than policies covering benefits exempt under HIPAA. The fee also applies to self-insured plans.